NEW PATIENT INFORMATION FORM

			TODAYS DATE	
LAST NAME	FIRST NAME	MI	DOB	☐ Male ☐ Female
SSN	HOW DID YOU HEAR ABOUT US / REFERRED BY?			
MOBILE PH	HOME PH		OTHER PH	
EMAIL			PREFERRED METHOD OF CONTACT ☐ Mobile ☐ Home ☐ Other ☐ Email	
ADDRESS			APT/UNIT	
CITY	STATE		ZIP	
INSURANCE ☐ Self Pay ☐ Medicare ☐ Commercial:			EMPLOYER	
MEMBER ID		GROUP #		
SUBSCRIBER NAME	DOB	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other:		
SUBSCRIBER PHONE	SUBSCRIBER ADDRESS ☐ Same as Patient or:			
BENEFITS VERIFICATION		BH BENEFITS VERIFICATION		
DO YOU HAVE ANY OTHER INSURANCE? ☐ No ☐ Yes – Carrier:				
INSURANCE ☐ Medicare ☐ Commercial:			EMPLOYER	
MEMBER ID		GROUP #		
SUBSCRIBER NAME	DOB	SUBSCRIBER RELATIONSHIP ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other:		
SUBSCRIBER PHONE	SUBSCRIBER ADDRESS ☐ Same as Patient or:			
BENEFITS VERIFICATION		BH BENEFITS VERIFICATION		
Who is financially responsible for the billing? ☐ Patient ☐ Subscriber ☐ Other:				
RACE ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Unknown ☐ Declined				
ETHNICITY ☐ Hispanic ☐ Not Hispanic ☐ Unknown ☐ Declined		PREFERRED LANGUAGE ☐ English ☐ Other:		
REASON FOR CALL TODAY ☐ Medical Management ☐ Counseling ☐ Both ☐ Other:		PROVIDER ☐ Rakesh Amin, MD ☐ Andrew Pierce, MD ☐ Anand Patel, MD ☐ Kelley Bivens, LCSW ☐ Jessica Krepp, LCSW		
CURRENT STRESSORS OR OTHER REASON FOR VISIT:				
EMERGENCY CONTACT NAME	RELATIONSHIP		PHONE	
ADDRESS			APT/UNIT	
CITY	STATE		ZIP	
PHARMACY		PHONE NUMBER		
ADDRESS				

CURRENT MEDICATIONS

Please list all medications that you are currently taking, including all prescriptions, over the counter, herbal, and supplemental medications. *(additional space on last page if needed)*

DRUG	DOSE	FREQUENCY	PRESCRIBED BY

DRUG ALLERGIES

Please list all allergies, the reaction and severity. *(additional space on last page if needed)*

DRUG / FOOD	REACTION	SEVERITY

MEDICAL HISTORY

Please indicate if you have any of the following:

☐ Asthma	☐ Hepatitis A / B / C
☐ Blind	☐ High / Low Blood Pressure
☐ Cancer	☐ HIV / Aids
☐ Deaf	☐ Irregular Heart Rate
☐ Dementia	☐ Pregnant or Breast Feeding
☐ Diabetes	☐ Seizures / Epilepsy
☐ Dry Mouth	☐ Stroke
☐ Emphysema / COPD	☐ Thyroid Problems
☐ Fibromyalgia / Chronic Pain	☐Sexually Transmitted Disease
☐ Frequent Urinary Infections	☐Sleep Apnea

☐ Any other medical conditions

PSYCHIATRIC HISTORY

Please indicate if you have any of the following:

☐ Alcohol / Drug Abuse	☐ History of Suicide Attempt or Self Harm
☐ Anxiety	☐ History of Trauma; Physical / Sexual / Emotional
☐ Bipolar Disorder	☐ Panic Attacks
☐ Depression	☐ Post-Traumatic Stress Disorder
☐ Eating Disorder; Anorexia / Bulimia / Binge Eating	☐ Schizophrenia

☐ Any other psychiatric conditions

SOCIAL HISTORY			
CURRENT RELATIONSHIP STATUS ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed			NAME OF SPOUSE / PARTNER
EDUCATION ☐ Did not graduate High School ☐ High School Graduate ☐ Some College ☐ College Graduate ☐ Currently Enrolled			
EMPLOYMENT STATUS ☐ Unemployed ☐ Disabled ☐ Employed	OCCUPATION		NAME OF EMPLOYER
SMOKING STATUS ☐ Never Smoker ☐ Former Smoker ☐ Current Every Day Smoker: ☐ Tobacco (Cigarettes, Pipe, Cigar) ☐ Nicotine (E-Cigs, Vape)			
FAMILY HISTORY *Please indicate if anyone in your family had any of the following conditions:*			
☐ History of Mental Illness ☐ Suicide Attempt or Completion ☐ Alcohol / Drug Abuse ☐ Dementia / Alzheimer's			
If yes, please indicate your relationship (Mother, Father, etc.) and details of their condition, if known.			
Is there any other disease, condition, or problem that you think your Provider should know about that is not already covered above? If yes, please describe:			

CURRENT MEDICATIONS; CONTINUED *(additional space if needed)*			
DRUG	**DOSE**	**FREQUENCY**	**PRESCRIBED BY**

Signature of Patient or Authorized Representative	**Date**